Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1914	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - STATE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2010

NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 832	1200-8-6-.08(2) Building Standards (2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured. This Rule is not met as evidenced by: Based on inspection during the survey, it was determined, the facility failed to maintain the physical plant for the safety of both patients and staff as required. Tennessee Department Of Health (TDOH) 1200-8-6-08(2) The findings included: On 6/21/10 at 9:30 PM observation within the dietary area revealed two of the ceiling tiles were missing. The deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview.	N 832	1. On 06/22/10, the outside electrical contractor, who had just installed the electrical outlet, replaced the missing ceiling tiles. 2. On 06/25/10, the maintenance assistant inspected the building for damaged/missing ceiling tiles. No issues were found. 3. The maintenance assistant will inspect the facility monthly for missing/damaged ceiling tiles. 4. The Environmental Services Director will monitor the inspections for 3 months and cease monitoring if no issues are found.	07/13/10

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator

(X6) DATE 07/07/10

STATE FORM   6699   9JGX21   If continuation sheet 1 of 1

JUL 12 2010